Complete Summary

GUIDELINE TITLE

VHA/DoD clinical practice guideline for the management of substance use disorders.

BIBLIOGRAPHIC SOURCE(S)

Management of Substance Use Disorders Working Group. VHA/DoD clinical practice guideline for the management of substance use disorders. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Sep. Various p. [207 references]

GUIDELINE STATUS

This is a current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Substance use disorders, including:

- Alcohol abuse or dependence
- Opioid abuse or dependence

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management

Rehabilitation
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

- To promote evidence-based management of patients with substance use disorders
- To identify the critical decision points in the management of patients with substance use disorders
- To allow flexibility to local policies or procedures, such as those regarding referrals to or consultation with specialists
- To improve local management of patients with substance use disorders and thereby improve patient outcomes

TARGET POPULATION

Persons eligible for care in the Veterans Health Administration (VHA) or Department of Defense (DoD) health care delivery system

INTERVENTIONS AND PRACTICES CONSIDERED

Management in Primary Care

1. Assessment/Diagnosis:
    - Use of standardized alcohol screening procedures (e.g., the CAGE or Alcohol Use Disorders Identification Test [AUDIT])
    - Arrangement of detoxification or stabilization, if indicated
    - Identification of patients with hazardous substance use who should receive a brief intervention
    - Identification of patients with substance abuse or dependence who require a referral to specialty care
2. Brief Intervention:
    - Feedback to clients about screening results and health risks
    - Client education about safer consumption limits

- Assessment of patient readiness for change
- Negotiation with clients of goals and strategies for change

3. Referral to specialty care as clinically indicated for substance dependence.
4. Assistance to overcome barriers to successful referral.
5. Care Management:
    - Documentation of specific substance use at each contact by patient report
    - Monitoring of biological indicators (e.g., transaminase levels and urine toxicology screens) and discussion of results with the patient
    - Counseling patient regarding reduction or cessation of use at each visit and support of motivation to change
    - Recommendations for self-help groups
    - Addressing of or referral for social, financial, and housing problems
    - Coordination of treatment with other care providers
    - Monitoring of progress and periodicity assessment for possible referral to specialty care rehabilitation
6. Follow-up:
    - Monitoring substance use and encouragement of continued reduction or abstinence
    - Patient education about substance use and associated problems

Specialty Care Rehabilitation

1. Assessment/Diagnosis:
    - Identification of the patient's current problems, relevant history, and life context as a basis for the integrated summary and initial treatment planning
    - Identification of patients with nicotine dependence for which cessation treatment may be effective
    - Identification of the patient who does not require specialty care and coordination with primary care
    - In the Veterans Administration, completion of the Addiction Severity Index
    - Integration and prioritization of biopsychosocial assessment information as a basis for formulating the diagnosis and treatment recommendations
2. Management/Treatment:
    - Involvement of the patient in the creation and determination of a treatment plan
    - Clarification and/or encouragement of patient's commitment to rehabilitation goals
    - Identification of the least restrictive level of initial treatment intensity that will safely help the patient achieve early remission and prevent relapse
    - Facilitation of access to treatment and promotion of a supportive recovery environment
    - Addiction-focused psychosocial treatment including self-help group involvement
    - Addiction-focused pharmacotherapy (opioid agonists, such as methadone, levo-alpha-acetylmethadol (LAAM); naloxone challenge; naltrexone; disulfiram)
    - Individualized treatment to address co-morbid conditions

- Summarization, simplification, and solidification of the recovery plan to maximize the patient's chances for achieving his/her rehabilitation goals

3. Follow-up:
    - Periodic reassessment of response to treatment, change in treatment goals, or other indications for change in the treatment plan
    - Provision of appropriate continuity of care with primary medical or behavioral health care providers
    - Promotion of abstinence or reduced use

MAJOR OUTCOMES CONSIDERED

- Reliability and accuracy of assessment instruments
- Remission rates, maintenance of remission, relapse rates
- Morbidity and mortality related to substance abuse
- Medical, psychiatric and social outcomes
- Quality of life
- Need for high-intensity health care services
- Patient acceptance of treatment and counseling
- Adverse effects of pharmacologic management

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The guideline developers performed electronic searches of Cochrane Controlled Trials Register. Papers selected for further review were those published in English-language peer-reviewed journals. Preference was given to papers based on randomized, controlled clinical trials, or nonrandomized case-control studies. Studies involving meta-analysis were also reviewed.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Grading

I. Evidence is obtained from at least one properly randomized clinical trial (RCT).

II-1. Evidence is obtained from well-designed controlled trials without randomization.

II-2. Evidence is obtained from well-designed cohort or case-control analytical studies, preferably from more than one center or research group.

II-3. Evidence is obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.

III. Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review with Evidence Tables

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Selected articles were identified for inclusion in a table of information that was provided to each expert participant. The table of information contained: Title, Author(s), Author(s) affiliation, Publication type, Abstract and Source. Copies of these tables were made available to all participants. In addition, the assembled experts suggested numerous additional references. Copies of specific articles were provided to participants on an as-needed basis. This document includes references through the year 2000.

Rating of the Evidence

Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research. The working group reviewed the articles for relevance and graded the evidence using the rating scheme published in U. S. Preventive Service Task Force (USPSTF) Guide to Clinical Preventive Services, Second Edition (1996). The experts themselves formulated quality of evidence (QE) ratings, after an orientation and tutorial on the evidence grading process. Each reference was appraised for scientific merit, clinical relevance, and applicability to the populations served by the Federal health care system. The quality of evidence rating is based on experimental design and overall quality. Randomized controlled trials received the highest ratings (QE=I), while other well-designed studies received a lower score (QE=II-1, II-2, or II-3). The quality of evidence rating is based on the quality, consistency, reproducibility, and relevance of the studies.

The working group formulated a recommendation rating (R), using a rating scale from A to E. The rating of R is influenced primarily by the significance of the scientific evidence. Other factors that are considered when making the R determination include standards of care, policy concerns, and cost of care.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

In July 1998, a guideline for the Management of Persons with SUD was developed for the Veterans Health Administration (VHA). The initial guideline was the product of a research and consensus building effort among professionals throughout the VHA. Shortly after the development of the initial guideline, the Department of Defense (DoD) joined the VHA in developing clinical practice guidelines (CPGs). Since then the DoD has participated with the VHA in developing and disseminating several CPGs. The initial VHA guideline was not published and was used as the seed for development of the VHA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders in the Primary Care Setting. This guideline is the product of a close collaboration, which started in March 2000.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Strength of Recommendation Grading

A. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated.
B. A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered useful/effective.
C. A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds.
D. A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered not useful/effective.
E. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The quality of evidence grading (I-III) and strength of recommendation grading (A-E) are defined at the end of the "Major Recommendations" field.

The "Substance Use Disorder" guideline is presented in an algorithmic format and is intended to provide a systematic approach to the evaluation and management of patients with substance use disorders.

- Module A: Assessment and Management in Primary Care
- Module C: Care Management
- Module P: Addiction-Focused Pharmacotherapy
- Module R: Assessment and Management in Specialty Care
- Module S: Stabilization

Module A: Assessment and Management in Primary Care

A. Person With Active Substance Use Presenting In Primary Care

Patients managed within this module either indicated recent substance use, were screened for substance use or referred for further evaluation, or have manifested behaviors that place them at increased risk for relapse. They may or may not meet the Diagnostic and Statistical Manual of Mental Disorders-4th Edition (DSM IV) criteria for substance abuse or dependence.

The purpose of screening for substance use is to identify those who should receive additional screening for hazardous use or substance use disorders (SUDs). The initial screening is intended to rule out those patients for whom the provider identifies "no indications for further screening regarding substance use". All patients should be asked about any current or recent use of nicotine, alcohol, and/or other substances at their initial visit or at least annually. Specifically, a clinician must have a high index of suspicion and realize patients with substance use disorders commonly enter health care through the emergency room, acute care, routine care, and chronic care routes.

B. Obtain History, Physical Examination, Laboratory Tests, Mental Status Examination (MSE), And Medication (Including Over-The-Counter [OTC])

Objective

Obtain clinical background information on the patient.

Annotation

1. Interview the patient and other collateral informants, where appropriate, about medical history and use of prescription and non-prescription medications before initiating extensive diagnostic testing.
2. Note any history of recent head trauma.
3. Order laboratory tests selectively, aiming to detect potential medical causes for the presenting symptoms where indicated by:
    - Specific symptoms found on the medical review of systems
    - Evidence of unusual symptom profiles
    - History of atypical illness course
4. Screen for cognitive status, particularly in the elderly patient:
    - Consider a standardized instrument such as Folstein's Mini-Mental State Examination (MMSE), using age and education-adjusted cut-off scores
    - History of atypical illness course
5. For the Department of Defense (DoD) patients the commanding officer can be an excellent source of collateral data.

C. Is Patient Medically or Psychiatrically Unstable or Acutely Intoxicated?

Objective

Identify the patient who needs to be stabilized before continuing in the algorithm.

Annotation

Patients with problems that require emergency care or urgent action should not be further managed by this algorithm. Emergency or urgent actions include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., delirium and imminent risk of harm to self and/or others).

Delirium

Delirium can be identified through the following:

1. Disturbance of consciousness (e.g., reduced clarity of awareness of the environment with reduced ability to focus, sustain, or shift attention).
2. A change in cognition (such as memory deficit, disorientation, or language disturbance) or the development of a perceptual disturbance that is not accounted for by a preexisting, established, or evolving dementia.
3. The disturbance develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day.
4. There is evidence from the history, physical examination, or laboratory findings that:
    - Illness is characterized by an atypical course
    - Disturbances are caused by the direct physiological consequences of a general medical condition
    - Symptoms developed during substance intoxication or medication use are etiologically related to the disturbance

- Symptoms are developed during or following a withdrawal syndrome
- Delirium has more than one etiology (e.g., a general medical condition plus intoxication or a medication side effect)

Risk of harm to self or others

5. If suicidal ideation is present, the imminent risk increases with one or more of the following risk factors:
    - Prior suicide attempt and lethality of prior acts
    - Level of intent and formulation of plan
    - Greater preoccupation (e.g., frequency, intensity, and duration of thoughts)
    - Availability of lethal means for suicide (e.g., firearms or pills)
    - Family history of completed suicide
    - Presence of active mental illness (e.g., severe depression or psychosis)
    - Presence of substance abuse
    - Current negative life events (e.g., loss in personal relationship)
    - Feelings of hopelessness or helplessness
6. Consider the patient's history of violent acts as an increased risk for violence toward self or others.
7. Offer mental health counseling to patients with evidence of suicidal, assaultive, or homicidal ideation.
8. Arrange voluntary or involuntary emergency psychiatric treatment and possibly hospitalization for patients with definite intent to harm self or others, particularly those with a plan and the available means.

Serious psychiatric instability

Obtain immediate mental health consultation if other psychiatric symptoms (e.g., acute psychosis) significantly interfere with further assessment and require immediate psychiatric treatment before continuing assessment.

Acute intoxication

9. The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
10. Patients should be medically observed at least until blood levels are decreasing and the clinical presentation is improving.
11. Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at blood alcohol levels (BAL) well above the legal limit (e.g., 80 or 100).

Recommendations

12. Assess imminent risk for suicide (U.S. Preventive Services Task Force [USPSTF], 1996) (II-2, A).
13. Note increased risk for violence (Hasting & Hamberger, 1997; Thienhaus & Piasecki, 1998) (III, A).

14. Offer counseling to a patient at risk (Hirschfield & Russell, 1997; USPSTF, 1996) (III, A).
15. Arrange emergency treatment or possible hospitalization (American Psychiatric Association [APA], 1993; U.S. Department of Health and Human Services [USDHHS], 1993, 1995; USPSTF, 1996; Veterans Administration [VA] Task Force) (III, A).

D. Provide Appropriate Care To Stabilize Or Consult; Follow Legal Mandates;
For DoD Active Duty: Keep Commanding Officer Informed

Objective

Provide services to stabilize the patient's condition.

Annotation

1. Implement suicide or high-risk protocols, as needed.
2. Review local policies and procedures with regard to threats to self or others. These policies reflect local and state laws and the opinion of the Veteran Administration District Council and the U.S. Department of Defense (DoD). Primary care, mental health, and administrative staff must be familiar with these policies and procedures.
3. For DoD active duty: Follow service specific mandates, as a mental health/emergency referral is likely mandated.

E. Does Patient Exhibit:
I. Hazardous Substance Abuse?
II. Abuse of Dependence?
III. Risk of Relapse?

Objective

Identify patients who require clinical intervention related to their substance use beyond routine education about prevention of relapse.

Annotation

Interview the patient and consider use of the following:

4. Brief self-report screening instruments (see Section II of this annotation).
5. Reports from responsible others.
6. Laboratory tests (for corroboration only and not for routine screening)-e.g., blood or breath alcohol levels, breath carbon monoxide for smoking, urine toxicology, elevated carbohydrate deficient transferrin, increased mean corpuscular volume (MCV), or gamma glutamic transferase (GGT). Laboratory tests are not recommended for screening of asymptomatic persons.

VII. Screening for hazardous substance use

The clinician should identify patients who are currently using substances at hazardous levels whether or not they meet diagnostic criteria for substance abuse or dependence.

Hazardous alcohol use

Screen current users for hazardous alcohol use at the initial clinic visit or at least annually.

1. Screening for hazardous alcohol use should consider both the volume (e.g., total drinks per week) and pattern of use (e.g., frequency of heavy drinking episodes).
    - Average weekly or daily quantity is most strongly related to chronic health risks
    - Frequency of heavy drinking is most strongly related to acute health risks and psychosocial risks
2. Patients are at increased risk of medical morbidity and dependence if they report drinking more than the gender specific hazardous use threshold (see Table 1 titled "Hazardous Alcohol Use Screening" in the original guideline document).

Other hazardous substance use

3. Screen all patients for nicotine usage. Utilize the VHA/DoD Clinical Practice Guideline Tobacco Use Cessation in the Primary Care Setting.
4. Determination of hazardous use for other drugs (where criteria for abuse or dependence are not met) is not well studied. There are no unequivocal quantity or frequency risk thresholds for hazardous use of psychoactive drugs. Any use may impair judgment or performance and involves some degree of risk. However, regular use of any intoxicant (e.g., daily or several days per week) suggests at the least a high risk for abuse or dependence. Some drugs, such as cocaine and heroin, are potentially toxic even with occasional use. Individuals using intoxicants such as cannabis, amphetamines, heroin, or cocaine should be cautioned about the health risks associated with such use and urged to discontinue use. For Department of Defense active duty: follow service specific mandates, as a mental health/emergency referral is likely mandated.
5. Long-term use of prescribed opioids, anxiolytics, or hypnotics does not in itself constitute hazardous use, abuse, or dependence. However, use of these medications must be carefully considered in each case. Refer to Module S: Stabilization (Annotation F) in the original guideline document for a discussion about prescribing opioids for chronic pain. Many of the same considerations are relevant to long-term prescription of anxiolytics and hypnotics. Clear indications of problematic use include frequent early requests for refills, escalating demands for dose increases beyond that justified by the medical condition, attempts to obtain prescriptions from multiple providers, episodes of intoxication, or use of medications with intoxicants such as alcohol or illicit drugs. When in doubt about whether use is hazardous or abusive, consult a specialist in the management of the underlying disorder (e.g., pain, insomnia, or anxiety) or addiction medicine.

VIII. Screening for substance abuse or dependence

Alcohol abuse or dependence

Consider a screen positive for alcohol abuse or dependence, if a patient:

0. Scores eight or more on the Alcohol Use Disorders Identification Test (AUDIT) (see Appendix A-1 in the original guideline document).

or

1. Endorses two or more of the four items reflected in the acronym CAGE (see Appendix A-1 of the original guideline document):

- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticizing your drinking?
- Have you ever felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye opener)?

Other substance abuse or dependence

2. Screening for other drug use may be appropriate in some clinical settings (e.g., adolescent or AIDS clinics), but has not been recommended as routine by the USPSTF.

3. The Drug Abuse/Dependence Screener is a 3-item screen with excellent preliminary validity in community populations (see Appendix A-1 in the original guideline document). It may be useful in primary care settings when the provider identifies an indication for screening.
4. The Two-Item Conjoint Screen (TICS) has been used in primary care to identify patients with current alcohol or other drug problems.
5. The Drug Abuse Screening Test (DAST) is a 28-item (or abbreviated 10-item version) instrument to identify adverse consequences of substance abuse, but it has not been well studied in primary care settings.

DSM-IV criteria for substance abuse

6. A maladaptive pattern of substance abuse leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12-month period:

- Recurrent substance use resulting in failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; or neglect of children or household).

- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine).
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
- Continued substance use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication or physical fights).

7. These symptoms must never have met the criteria for substance dependence for this class of substance.

Assessment of substance dependence

h. Conduct clinical assessment to see if the patient meets the DSM-IV diagnostic criteria for substance dependence (see original guideline document for diagnosis codes).

i. Diagnostic criteria required for substance dependence involves more than evidence of physiological dependence.
j. Consider whether the person is dependent on multiple substances.

DSM-IV criteria for substance dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three or more of the following seven criteria, occurring at any time in the same 12-month period:

11. Tolerance, as defined by either of the following:
- A need for markedly increased amounts of the substance to achieve intoxication or desired effect
- Markedly diminished effect with continued use of the same amount of the substance

12. Withdrawal, as defined by either of the following:
- The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details)
- The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

13. The substance is often taken in larger amounts or over a longer period than was intended
14. There is a persistent desire or there are unsuccessful efforts to cut down or control substance use.
15. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances to see one), use the substance (e.g., chain smoking), or recover from its effects.
16. Important social, occupational, or recreational activities are given up or reduced because of substance use.
17. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is

likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Dependence exists on a continuum of severity: remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as Early (first 12 months) or Sustained (beyond 12 months) and Partial (some continued criteria met) versus Full (no criteria met).

IX. Screening for risk of relapse

A relapse is defined as any discrete violation of a self imposed rule or set of rules governing the ability to either stay completely free of drug use or maintain a preset goal of reduced drug usage. Variables that may place an individual at increased risk for relapse include the following:

0. Negative/unpleasant emotional states (e.g., anger, frustration, depression, boredom, or anxiety)
1. Interpersonal conflict
2. Social pressure to engage in drug usage (may be direct or indirect)
3. Negative physical states (e.g., chronic or acute pain or substance withdrawal)
4. Testing personal control over the use of the substance
5. Responsivity to substance cues (e.g., cravings or urges)

A simple and brief patient inquiry will often suffice, such as "Have you had any 'close calls' with drinking or other drug use?"

Recommendations

6. Use of labs (Anton et al., 1995) (II-2, A).
7. Screening of asymptomatic patients (USPSTF, 1996) (II-2, D).
8. Annual screening of hazardous use (USPSTF, 1996; USDHHS, 1995) (III, B).
9. Consider volume and use (Hawks, 1994; Room et al., 1995; Hasin et al., 1996; Midanik et al., 1996) (II-2, A).
10. Use of Alcohol Use Disorders Screening Test (AUDIT) score (Saunders et al., 1993) (II-1, A).
11. Use of Alcohol abuse/dependence screening instrument (CAGE) score (Mayfield et al., 1974) (II-2, A).
12. Routine screening for other drug abuse or dependence (USPSTF, 1996) (III, D).
13. Use of Drug Abuse/Dependence Screener (Schorling & Buchsbaum, 1997) (III, C).
14. Use of Two-Item Conjoint Screen (TICS) score (Brown et al., 1997) (II-3, B).
15. Use of Drug abuse/Dependence Screener (DAST) score (Skinner, 1982) (III, C).

F. Initiate Concurrent Physiological Stabilization, If Required

Objective

Identify patients in need of further assessment within Module S: Stabilization.

Annotation

Indications for stabilization include intoxication or risk of withdrawal:

0. Intoxication:
    - The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
    - Patients should be medically observed at least until the blood alcohol level is decreasing and clinical presentation is improving.
    - Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at blood alcohol levels well above the legal limit (e.g., 80 or 100 mg percent).

1. Consider withdrawal risk from each substance for patients using multiple substances. Table 2, Module A in the original guideline document summarizes signs and symptoms of intoxication from alcohol and sedative-hypnotics, cocaine or amphetamine, opiates. The original guideline document also presents a detailed discussion on symptoms of withdrawal from opioid, sedative-hypnotics or alcohol. These signs and symptoms are also presented in Module S Stabilization, Annotation E, of this summary.

Recommendations

Consider using standardized assessment of withdrawal symptoms (Sullivan et al., 1989; Gossop, 1990; Zilm & Sellers, 1978) (II-2, A)

G. Summarize And Educate The Patient About The Problem

Objective

Present assessment information to the patient in a way that motivates ongoing cooperation with the provider and supports subsequent decisions about referral or brief intervention.

Annotation

0. Discuss the patient's current use of alcohol and other drugs and address any potential problem areas (e.g., recent initiation of use, increase in use, or relationship to presenting medical concerns).
    1. Inform the patient about relevant potential age- and gender-related problems, such as:
        - Abusive drinking or other drug use in the young adult
        - Alcohol and other drug use during pregnancy
        - Medication misuse or heavy drinking in the older adult

2. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
3. Emphasize appropriate concern and encourage the patient to address the problem.
4. Motivate the patient to seek additional treatment when indicated.

H. Is Specialty Referral Indicated Or Mandated?

Objective

Determine, along with the patient, the most appropriate treatment approach.

Annotation

0. When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
1. Care management is likely to be a more acceptable and effective alternative when one of the following applies:
- The patient refuses referral to rehabilitation but continues to seek some services, especially medical and/or psychiatric services.
- The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
- The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward optimal or intermediate rehabilitation goals.

2. Regarding DoD active duty patients:
- Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Appendix A-2 of the original guideline document).
- Should such patients refuse referral, the commanding officer must be notified so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (administrative separation from service, etc.), or (c) do nothing. This is the commander's decision, with input from the medical staff.

Review the clinical assessment and note past treatment response, motivational level and patient goals in order to match patient needs and available programming.

Recommendations

3. Referral to specialty care (Gerstein & Harwood, 1990; Institute of Medicine [IOM], 1990) (I, A).
4. Consider care management for medically ill alcoholics (Willenbring et al., 1995; Willenbring et al., 1999) (I, B).
5. Consider care management for combined serious psychiatric disorders and substance use disorders, where participation in rehabilitation programs is precluded (Drake & Mueser, 2000; Osher & Drake, 1996; USDHHS, 1994) (II-1, B).

6. Match patient's motivational level and needs with available programming (American Society of Addiction Medicine [ASAM], 1996) (III, A).

I. Does Patient Agree To Referral Or Is Referral Mandated?

Objective

Promote enhanced patient commitment to change and adherence to the planned treatment regimen.

Annotation

Negotiate and set specific rehabilitation goals with the patient:

0. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
    1. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
    2. Use motivational enhancement techniques, when appropriate.
    3. Consider bringing the addiction specialist into your office to assist with referral decisions.
    4. Regarding DoD active duty:
        - Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Appendix A-2 in the original guideline document).
        - Should such patients refuse referral, notify the commanding officer so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

Recommendations

5. Establish treatment goals through negotiation (Heinssen et al., 1995; Miller, 1995; Miller & Rollnick, 1991; Sanchez-Craig & Lei, 1986; Sobell et al., 1992; Stark, 1992) (II-1, A).
    6. Review prior treatment experience (Stark, 1992) (III, B).

J. Refer To Specialty Care With Attention To Engagement Barriers

Objective

Ensure adequate financial, housing, transportation, and social resources to support access to treatment at the appropriate level of care and provide a supportive recovery environment.

Annotation

Address and remove barriers to treatment. If resources are not present or readily available refer to social work services for assistance.

Accessible transportation, appropriate for individual needs, is necessary for patient participation in treatment and follow-through on plans. Resources to meet basic needs for food, clothing, and personal care should also be allocated. Patient assessment and referral requires a thorough understanding of needs, present resources, preferences, expectations and perceptions, and eligibilities, as well as community resources and regulations.

K. Provide Brief Intervention

Objective

Promote reduced hazardous use of alcohol and other drugs and prevent future complications or dependence.

Annotation

A brief intervention may be accomplished in the following general sequence:

0. Give feedback about screening results, relating the risks of negative health effects to the patient's presenting health concerns.
    1. Inform the patient about safe consumption limits and offer advice about change.
    2. Offer to involve family members in this process to educate them and solicit their input (consent is required).
    3. Assess patient's degree of readiness for change (e.g., "How willing are you to consider reducing your use at this time?").
    4. Negotiate goals and strategies for change.
    5. Schedule an initial follow-up appointment in two to four weeks.
    6. Monitor changes at follow-up visits by asking patient about use, health effects, and barriers to change.
    7. If patient declines referral to specialty evaluation or treatment, continue to encourage reduction or cessation of use and reconsider referral to specialized treatment at subsequent visits.

Recommendations

8. Provide feedback for screening results (Samet et al., 1996; USDHHS, 1995, 1997) (I, A).
    9. Address consumption limits and advise about change (Bien et al., 1993; Fleming et al., 1997; Poikolainen, 1999; Wilk et al., 1997) (I, A).
    10. Assess readiness for change (Adams et al., 1998; Miller & Rollnick, 1991) (I, A).

L. Follow-Up Primary care

Objective

Monitor substance use and encourage reduction or abstinence.

Annotation

Maintain a vigilant review of alcohol and other drug use by multiple modes of assessment, ranging from careful observation by provider during medical appointments to the use of biological measures. Promote abstinence or reduction, as indicated, and offer supportive verbal encouragements.

0. Look for spontaneous signs of use and ask the patient about their specific use and frequency of that use.
    1. When possible, discuss other areas of concern in the patient's life since these constitute collateral assessment and prognostic indicators.
    2. Use biological assessments concurrently with the ongoing dialogue including the breathalyzer, urine toxicology, and blood alcohol level.
    3. Encourage abstinence or reduced use, consistent with the patient's motivation and agreement.

M. Educate About Substance Use, Associated Problems, And Prevention Of Relapse

Objective

Prevent the development of problematic alcohol or other drug use, abuse, and dependence (primary prevention) or resumption of problems following a period of remission.

Annotation

0. Discuss the patient's current use of alcohol and other drugs and address any potential problem areas, such as recent initiation of use, increase in use, and use to cope with stress.
    1. Inform patient about potential age- and gender-related problems, such as:
        - Abusive drinking or other drug use in the young adult
        - Alcohol and other drug use during pregnancy
        - Medication misuse or heavy drinking in the older adult

2. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
    3. Periodically inquire about alcohol and drug use at future visits.

Recommendations

Future monitoring of substance use (Bradley et al., 1993; USDHHS, 1995) (III, B)

Module C: Care Management

A. Patient In Need Of Care Management

Patients with hazardous substance use/abuse, dependence, or risk of relapse who may benefit from a care management plan.

B. Is Care Management Acceptable To The Patient?

Objective

Identify and engage patients with substance use disorders (SUDs) who can benefit from implementation of a care management plan.

Annotation

The provider should distinguish the patient's refusal of all ongoing care from unwillingness to engage in specialized treatment for substance use disorders. Some patients refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction).

Recommendations

Identify the patient's willingness to engage in ongoing care (Willenbring et al., 1995) (III, B).

C. Implement/Continue Care Management Plan In Specialty Care Or Arrange In Primary Care

Objective

Begin care management in the setting most conducive to treatment engagement and management of co-morbid conditions.

Annotation

Care management is a clinical approach to the management of chronic substance use disorders where full remission (e.g., abstinence) is not a realistic goal or one the patient endorses. Conceptually, the care management approach is similar to managing other chronic illnesses, such as diabetes or schizophrenia. Practically, the care management framework provides specific strategies designed to enhance motivation to change, relieve symptoms and improve function, where possible, and monitor progress towards goals. Care management is a flexible approach that may be integrated into medical and psychiatric care in any setting. In some cases, care management will lead to remission of the substance use disorder or referral for specialty care rehabilitation, while in others it serves a more palliative function.

Care management components

1. Monitor and record specific substance use at each contact by patient report (e.g., drinking days during the past month, days of any substance use during the past month, and typical and maximum number of drinks per occasion).
2. Monitor biological indicators (e.g., transaminase levels and urine toxicology screens).
3. Encourage abstinence or reduced substance use.
4. Enhance motivation to change using non-confrontational motivational interviewing techniques.
5. Educate about substance use and associated problems.
6. Recommend self-help groups.
7. Address or refer for social functioning needs.

8. Address or refer for financial and housing needs.
9. Address nicotine use as appropriate.
10. Initiate crisis intervention as needed.
11. Provide care coordination.

Encourage regular visits with medical or behavioral health care provider

12. Encourage patients to return for medical or psychiatric visits even if they will not accept specialty care for substance use disorders.
13. Encourage reduction or cessation of use at each subsequent visit and support motivation to change.
14. Address substance use as a health care issue in all health care settings:
    - Obtain and record specific usage patterns at each visit (e.g., drinking days during the past month, days of any substance use during the past month, and typical number of drinks per occasion).
    - Clarify the link between presenting medical and psychiatric conditions and substance use, with feedback about physical findings and lab results (e.g., blood pressure and gamma glutamic transferase).
    - Use a non-confrontational, health education approach to enhance the patient's motivation for change.

Recommendation

Apply care management approach and address substance use in all health care settings (Kristensen et al., 1983; Willenbring et al., 1999) (I, A).

D. Reassess Progress Periodically

Objective

Provide opportunity to improve treatment effectiveness.

Annotation

Reassessment of initial care management plans should occur within 90 days. The patient's progress and goals should be reassessed and the treatment plan updated, at least annually, in established patients. Treatment plans should also be reviewed after significant clinical change (e.g., hospital admission, relapse, and accomplishment of care goals).

E. Has Stable Remission Been Achieved?

Objective

Assess response to care management plan and appropriateness of other follow-up options.

Annotation

Assess progress toward current goals.

Remission requires a period of at least 30 days without meeting full diagnostic criteria and is specified as Early (first 12 months) or Sustained (beyond 12 months) and Partial (some continued criteria met) versus Full (no criteria met).

Consider follow-up with primary care provider if stable remission is achieved.

If the patient is not in stable remission, identify new problems and goals to promote treatment engagement and modify the care management plan consistent with the patient's goals and preferences. Patients frequently become more accepting of treatment over time, particularly with worsening of substance-associated problems. If the patient indicates willingness to consider engaging in more intensive treatment, consider his or her appropriateness for rehabilitation (see Annotation H).

F. Follow-Up In Primary Care

Objective

Monitor substance use and encourage reduction or abstinence.

Annotation

Maintain vigilant review of alcohol and other drug use by multiple modes of assessment ranging from careful observation by the provider during medical appointments to the use of biological measures. Promote abstinence or reduction, as indicated, and offer supportive verbal encouragements.

1. Look for spontaneous signs of use and ask the patient about their specific use and frequency of that use.
2. When possible, discuss other areas of concern in the patient's life since these constitute collateral assessment and prognostic indicators.
3. Use biological assessments including the breathalyzer, urine toxicology, and blood alcohol level concurrently with the ongoing dialogue.
4. Encourage abstinence or reduced use consistent with the patient's motivation and agreement.

G. Educate About Substance Use, Associated Problems, And Prevention Of Relapse

Objective

Prevent the development of problematic alcohol or other drug use, abuse, and dependence (primary prevention) or resumption of problems following a period of remission.

Annotation

1. Discuss the patient's current use of alcohol and other drugs and address any potential problem areas, such as recent initiation of use, increase in use, and use to cope with stress.
2. Inform the patient about potential age- and gender-related problems, such as:
    - Abusive drinking or other drug use in the young adult
    - Alcohol and other drug use during pregnancy
    - Medication misuse or heavy drinking in the older adult
3. Convey openness to discuss any future concerns that may arise and encourage the patient to discuss them with you.
4. Periodically inquire about alcohol and drug use at future visits.

Recommendations

Future monitoring of substance use (Bradley et al., 1993; USDHHS, 1995) (III, B).

H. Is Specialty Referral Indicated And Acceptable To The Patient?

Objective

Promote enhanced patient commitment to change and adherence to the planned treatment regimen.

Annotation

Negotiate and set specific rehabilitation goals with the patient:

1. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
2. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
3. Use motivational enhancement techniques when appropriate.
4. Consider bringing the addiction specialist into your office to assist with referral decision.
5. Regarding DoD active duty:
    - Referral to addictions specialty care for assessment is required for all active duty patients involved in an incident involving/suspected to involve substances (see Module A, Appendix A-2 in the original guideline document).
    - Should such patients refuse referral, notify the commanding officer so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

Recommendations

6. Establish treatment goals through negotiation (Heinssen et al., 1995; Miller, 1995; Miller & Rollnick, 1991; Sanchez-Craig & Lei, 1986; Sobell et al., 1992; Stark, 1992) (II-1, A).
7. Review prior treatment experience (Stark, 1992) (III, B).

I. Provide Episodic Attention To Substance Use; Reassess Periodically

Objective

Encourage the patient to engage in ongoing care while addressing urgent concerns.

Annotation

Some patients refuse to engage in any type of ongoing care with any provider (e.g., medical, psychiatric, or addiction). These patients may require substantial emergency care and stabilization and may repeatedly present in crisis, but are not willing to return for outpatient visits or engage in alcohol and/or drug treatment.

Episodic attention to substance use may be accomplished by the following:

1. Provide crisis intervention, as needed.
2. At any contact initiated by the patient:
    - Assess current substance use.
    - Recommend that the patient accept ongoing care in the most appropriate setting.
3. Designate a single provider to coordinate care for patients who repeatedly present in crisis.
4. Consider involving supportive family members or significant others, if the patient agrees.
5. Initiate involuntary treatment procedures, if imminent threat to safety occurs (e.g., suicidal, violent, or unable to care for self).

Module P: Addiction-Focused Pharmacotherapy

A. Patient With Substance Use Disorder (SUD)

Patients managed within this module meet the criteria for substance abuse or dependence and are considered for addiction-focused pharmacotherapy.

B. Is The Patient Opioid Dependent?

Objective

Establish the patient's dependence on opioids.

Annotation

See Module A: Assessment and Management in Primary Care, Annotation E.

C. Is Opioid Agonist Therapy (OAT) Appropriate For And Acceptable To The Patient?

Objective

Assure careful consideration of opioid agonist therapy as the first line treatment for opioid dependence. For DoD active duty, opioid agonist therapy is generally not a treatment option.

Annotation

Opioid dependence is a cluster of cognitive, behavioral, and physiological symptoms characterized by repeated self-administration and usually results in opiate tolerance, withdrawal symptoms, and compulsive drug taking, despite negative consequences. While new federal regulatory language uses the term "opiate addiction", the diagnostic term opioid dependence will be used here for consistency with the rest of the guideline. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal. Opioid agonist therapy for opioid dependence consists of administering an opioid agonist medication, such as methadone or levo-alpha-acetylmethadol (LAAM), in combination with a comprehensive range of medical, counseling, and rehabilitative services. By administering an opioid to prevent withdrawal, reduce craving, and reduce the effects of illicit opioids, the opioid dependent patient is able to focus more readily on recovery activities. When compared to detoxification attempts, opioid agonist therapy is more successful in achieving the long-term goal of reducing opioid use and the associated negative medical, legal, and social consequences.

Provide access to opioid agonist therapy for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment (See Module R: Assessment and Management in Specialty Care).

1. Consider methadone maintenance for its documented efficacy in reducing illicit opioid use, human immunodeficiency virus (HIV) risk behavior, and drug-related criminal behavior.
2. Consider levo-alpha-acetylmethadol, a long-acting, synthetic mu-agonist, a safe and effective alternative to methadone maintenance.
3. Consider the acceptability and feasibility of regular clinic attendance. Under Federal regulations of opioid agonist therapy programs, for the first 90 days of treatment the patient should attend clinic at least six days per week for methadone or three times per week for levo-alpha-acetylmethadol.
4. Refer to Table 1 in the original guideline document for indications, contraindications, side effects, and drug interactions of methadone and levo-alpha-acetylmethadol.

Recommendations

5. Consider opioid agonist therapy the first-line treatment for opioid dependence (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; Sees et al., 2000) (I, A)

6. Methadone maintenance at adequate doses is efficacious in reducing opioid use (Strain et al., 1993a, 1993b; Marsch, 1998; Johnson et al., 2000) (I, A).
7. Levo-alpha-acetylmethadol (LAAM) maintenance at adequate doses is an effective alternative to methadone maintenance (Eissenberg et al., 1997; Glanz et al., 1997) (I, A).

D. Initiate Or Continue Opioid Agonist Therapy (OAT)

Objective

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

Annotation

Methadone

For newly admitted patients, the initial dose of methadone should not exceed 30 mg and the total dose for the first day should not exceed 40 mg, without provider documentation that 40 mg did not suppress opioid withdrawal symptoms.

Under usual practices, a stable, target dose is greater than 60 mg/day and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Effective May 2001, Federal regulations no longer require the opioid agonist therapy program physician to justify in the patient record doses > 100 mg/day.

Levo-alpha-acetylmethadol (LAAM)

For newly admitted patients, the initial 48-hour dose of levo-alpha-acetylmethadol should not exceed 40 mg. After dose induction, a stable target dose is usually at least 50/50/70 mg administered on Monday/Wednesday/Friday and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Friday doses are increased 40% to compensate for the 72-hour inter-dose interval. For patients on established doses of methadone, the relative potency of 48-hour levo-alpha-acetylmethadol doses is 1.2-1.3 times the daily methadone dose.

Opioid Agonist Therapy

Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).

Deliver opioid agonist therapy in the context of a complete treatment program that includes counseling or psychotherapy (See Module R: Assessment and Management in Specialty Care).

- Methadone, combined with weekly counseling for at least four weeks after admission, followed by at least monthly counseling, has been shown to be more effective than methadone alone.
- Availability of more frequent counseling is associated with less illicit drug use.
- No specific form of psychosocial intervention has consistently been shown to be more or less efficacious.
- Programs with high-quality social services show better treatment retention.
- Programs must provide adequate urine toxicology for drugs of abuse, including a minimum of eight random tests per year, per patient.

Recommendations

6. Methadone target dose is typically > 60 mg/day (Strain et al., 1999; Preston et al., 2000) (I, A).
7. Methadone combined with regular counseling is more effective than methadone alone (McLellan et al., 1993) (I, A).
8. Frequent counseling is associated with less illicit drug use (Magura et al., 1999) (II-2, A).
9. High-quality social services show better treatment retention (Condelli, 1993) (I, A).
10. Levo-alpha-acetylmethadol (LAAM) target dose is typically at least 50/50/70 mg on Monday/Wednesday/Friday (Jones et al., 1998; Eissenberg et al., 1997) (I, A).

E. Is Naltrexone Appropriate For And Acceptable To The Patient?

Objective

Identify patients who may benefit from naltrexone for opioid dependence.

Annotation

0. Naltrexone has no positive psychoactive effects and is unpopular with many opioid dependent patients. However, some highly motivated patients can be successful using naltrexone therapy.
1. Subpopulations with better prognosis for response include:
    - Patients highly motivated for abstinence without obvious external pressure
    - Patients in the criminal justice system, with monitored administration
    - Health care workers with employment-related monitoring
2. Avoid an adverse opioid withdrawal reaction precipitated by naltrexone during lingering physiological dependence. Such reactions can result in extreme reluctance to trust treatment of any modality.
3. Consider opioid agonist therapy programs or long-term therapeutic community approaches for chronic opioid dependent patients.

Recommendations

4. Naltrexone should be used selectively for highly motivated patients (O'Brien, 1996) (III, A).

5. Consider naltrexone, combined with monitored administration, for patients in the criminal justice system (Cornish et al., 1997) (I, B).
6. Consider naltrexone for health care workers with employment-related monitoring (Ling & Wesson, 1984) (II-2, B).

F. Assure Patient Is Detoxified And Opioid Free Before Continuing

Objective

Avoid precipitating an opioid withdrawal syndrome.

Annotation

Consider pharmacologically assisted detoxification (see Module S: Stabilization, Annotation F), unless the patient successfully completed a naloxone challenge and/or has had at least 7-10 days of verified abstinence.

Two major problems with opioid detoxification have been identified:

- Extremely high relapse rates.
- Absence of standard detoxification protocols; therefore, individualized detoxification regimens are required, regardless of the detoxification agent involved.

There are several methods to resolve uncertainty about physiological dependence on opioids:

- Self-report
- Urine toxicology screening
- Medical record review
- Physical examination (e.g., stigmata of intravenous (IV) use or symptoms of opioid withdrawal)
- Intoxication

Confirming the physiological dependence can also be accomplished with a challenge using naloxone, a short acting narcotic antagonist, to elicit signs and symptoms of precipitated withdrawal. A naloxone challenge should be done selectively and with great care (e.g., by or in close consultation with a physician experienced in management of opioid withdrawal) since patients can rapidly experience serious opioid withdrawal.

- Give 0.2 - 0.4 mg of naloxone, subcutaneously or intravenously, and the precipitated withdrawal usually begins within minutes.
- Patients with low levels of opioid use may require up to a total dose of 0.8 mg of naloxone to precipitate withdrawal, given in increments of 0.2 mg every 30 minutes.
- Symptoms usually peak within 30 minutes and subside in 3-4 hours.
- An oral dose of 5 or 10 mg of methadone may attenuate the withdrawal.

G. Initiate Naltrexone For Opioid Dependence With Patient Education And Monitoring

Objective

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

Annotation

Naltrexone has been shown to be safe and effective in blocking mu-opiate receptors and has been approved by the Food and Drug Administration (FDA) for treatment of opioid dependence since 1983. Studies show safety and efficacy for up to several years of treatment at standard doses (refer to Table 3 in the original guideline document for dosage, alternative dosing schedules, baseline evaluation, patient education, and monitoring of patients on naltrexone therapy).

H. Is The Patient Alcohol Dependent?

Objective

Identify patients with alcohol dependence who should be considered for addiction-focused pharmacotherapy.

Annotation

See Module A: Assessment and Management in Primary Care, Annotation E.

I. Is Pharmacotherapy For Alcohol Dependence Indicated?

Objective

Identify patients who may benefit from pharmacotherapy.

Annotation

There are two medications currently approved for the treatment of alcohol dependence-- naltrexone and disulfiram (refer to Table 4 in the original guideline document for indications, contraindications, side effects, and drug interactions with each medication). Pharmacotherapy has been shown to be effective when combined with addiction-focused counseling. Efficacy in the absence of counseling is uncertain.

- Naltrexone, an opioid antagonist, should be routinely considered when treating alcohol dependence. It has been shown to significantly reduce the relapse rate during the first 12 weeks of treatment when combined with addiction counseling.
- Disulfiram should be considered more selectively. Monitored administration significantly improves compliance. When cocaine and alcohol dependence occur together (which they frequently do) use of disulfiram is associated with reductions in both cocaine and alcohol use. Disulfiram should only be used when abstinence is the goal.

Recommendations

2. Consider naltrexone for alcohol dependence when combined with addiction counseling (O'Malley et al., 1996; Volpicelli et al., 1992; Center for Substance Abuse Treatment (CSAT), 1998; Anton et al., 1999; Garbutt et al., 1999) (I, A).
3. Monitored naltrexone administration significantly improves compliance (Garbutt et al., 1999) (II-1, A).
4. Consider disulfiram for coexisting cocaine and alcohol dependence (Carroll et al., 1998; McCance-Katz et al., 1998; George et al., 2000; Petrakis et al., 2000) (I, B).

J. Initiate Pharmacotherapy For Alcohol Dependence With Patient Education And Monitoring

Objective

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

Annotation

Refer to Table 5 in the original guideline document (Pharmacotherapy Management For Alcohol Dependence) for dosage, alternative dosing schedules, baseline evaluation, patient education, and monitoring of naltrexone and disulfiram for alcohol dependence.

Recommendations

Negotiate commitment regarding monitored ingestion of naltrexone (Volpicelli et al., 1997; Pettinati et al., 2000) (I, A)

Module R: Assessment and Management in Specialty Care

A. Patient With Substance Use Disorder (SUD) Referred To Specialty Care For Evaluation And/Or Treatment

Patients may be referred to this module based on the following indications for treatment: hazardous substance use, substance abuse, substance dependence, risk of relapse, or mandated referral within the DoD. Patients identifying or willing to consider optimal or intermediate rehabilitation goals are appropriately managed using this module. Other patients may be ambivalent about rehabilitation goals and may benefit from more comprehensive assessment and discussion of treatment options. Finally, patients may be referred to a specialist for more extensive evaluation of substance use.

B. Complete Physiologic Stabilization, If Necessary

Objective

Assure patient safety and readiness to cooperate with further assessment.

Annotation

Most patients managed within this module are not acutely intoxicated or in need of immediate physiological stabilization (see Module A: Assessment and Management in Primary Care) prior to initiating assessment and treatment planning. Others may have been stable at the time of referral, but require stabilization when they present for specialty care evaluation or treatment and should be managed using Module S: Stabilization.

C. Obtain A Comprehensive Biopsychosocial Assessment

Objective

Identify the patient's current problems, relevant history, and life context as a basis for the integrated summary and initial treatment plan.

Annotation

Include the following 10 general categories in a comprehensive assessment of substance use disorders:

1. Patient's demographics and identifying information, including housing, legal, and occupational status
2. Patient's chief complaint and history of the presenting complaint
3. Recent substance use and severity of substance-related problems
4. Lifetime and family history of substance use
5. Co-morbid psychiatric conditions and psychiatric history
6. Social and family context
7. Developmental and military history
8. Current medical status and medical history, including risk for HIV or hepatitis C
9. Mental status and physical examinations
10. Patient's perspective on current problems and treatment goals or preferences

D. Develop Integrated Summary And Initial Treatment Plan

Objective

Integrate assessment information from various sources, as a basis for formulating the diagnosis and treatment recommendations, followed by involvement of the patient in prioritizing problems and negotiating the initial treatment plan.

Annotation

1. Consolidate and interpret the information obtained during the assessment process in a narrative form.
2. Include a diagnostic formulation.
3. Review comprehensive assessment and integrated summary, including past treatment response.

4. Incorporate an interdisciplinary perspective in presenting treatment recommendations.
5. Involve the patient in prioritizing problems to be addressed in the initial treatment plan.
6. Review the patient's motivational level and goals and match the patient needs with available programming (see Treatment Plan and Expected Outcomes, below).
7. Identify treatment options and discuss them with the patient.

Treatment Plan and Expected Outcomes

Rehabilitation with optimal goals

- Complete and sustained remission of all substance use disorders
- Resolution of, or significant improvement in, all coexisting biopsychosocial problems and health-related quality of life

Rehabilitation with intermediate goals

- Short- to intermediate-term remission of substance use disorders or partial remission of substance use disorders for a specified period of time
- Resolution or improvement of at least some coexisting problems and health-related quality of life

Care Management

- Engagement in the treatment process, which may continue for long periods of time or indefinitely
- Continuity of care (case management)
- Continuous enhancement of motivation to change
- Availability of crisis intervention
- Improvement in substance use disorders, even if temporary or partial
- Improvement in coexisting medical, psychiatric, and social conditions
- Improvement in quality of life
- Reduction in the need for high-intensity health care services
- Maintenance of progress
- Reduction in the rate of illness progression

E. Can Treatment Plan Be Implemented In Primary Care?

Objective

Identify the patient who does not require specialty care.

Annotation

Consider the appropriateness of implementing the treatment plan in primary care, based on the following:

0. Review of the integrated summary and initial treatment plan.

1. Availability of a willing primary care provider with whom the patient has an ongoing clinical relationship.
2. Severity and chronicity of the substance abuse disorder.
3. Active involvement with support for recovery in the community.
4. Prior treatment response.
5. Patient preference and likelihood of adherence.

Consider rehabilitation in specialty care for more complex clinical presentations, especially where problem severity is greater or patient motivation is less clear (Annotation F).

F. Is Rehabilitation An Acceptable Mode Of Treatment To The Patient? For DoD Active Duty, A Referral Is Required. For Refusal, Contact Command To Discuss Administrative and Clinical Options

Objective

Determine, along with the patient, the most appropriate treatment approach.

Annotation

0. When acceptable to the patient, a specialty care rehabilitation plan is generally indicated.
1. Care management is likely to be a more acceptable and effective alternative when one of the following applies:
    - The patient refuses referral to rehabilitation, but continues to seek some services, especially medical and/or psychiatric services.
    - The patient has serious co-morbidity that precludes participation in available rehabilitation programs.
    - The patient has been engaged repeatedly in rehabilitation treatment with minimal progress toward optimal or intermediate rehabilitation goals.
2. Regarding DoD active duty patients:
    - DoD active duty refusing rehabilitation-contact command to discuss command directed treatment so consideration can be given to either (a) order the patient to comply, (b) invoke administrative options (e.g., administrative separation from service), or (c) do nothing. This is the commander's decision, with input from the medical staff.

G. Provide Motivational Intervention, Renegotiate Treatment Plan

Objective

Clarify and/or increase patient commitment to change.

Address barriers to, clarify, or promote patient readiness for rehabilitation goals.

Annotation

0. Establish treatment goals in the context of a negotiation between the treatment provider and the patient.
1. Review with the patient results of previous efforts at self-change and formal treatment, including reasons for treatment dropout.
2. Use motivational enhancement techniques reflecting the FRAMES model.
    - Feedback: Provide personalized feedback based on patient report of alcohol-related harm.
    - Responsibility: Emphasize patient responsibility and freedom of choice for changing behavior.
    - Advice: Provide clear and direct advice about the importance of change and availability of help.
    - Menu: Acknowledge and discuss alternative strategies for change.
    - Empathy: Maintain a patient-centered approach and accurately reflect patient statements and feelings.
    - Self-Efficacy: Emphasize the role of patient self-efficacy in their ability to make needed change and convey optimism in their potential to be successful.
3. Use empathic and non-judgmental (versus confrontational) therapist style.

Recommendations

Use empathic and non-judgmental (versus confrontational) therapist style (Hser, 1995; Miller et al., 1993; Najavits & Weiss, 1994) (I, A)

H. Determine Appropriate Initial Intensity Level Of Treatment

Objective

Identify the appropriate level of initial treatment intensity that will help the patient achieve early remission and prevent relapse.

Annotation

No standard dose or modality of treatment has been found to be uniformly sufficient for recovery. The initial intensity of treatment should:

0. Complement recovery support in the patient's community (e.g., Alcoholics Anonymous) and/or facilitate development of community support.
1. Coordinate with intervention(s) for other biopsychosocial problems. Increasing the intensity of addiction-focused treatments may not improve outcomes as effectively as addressing identified concurrent problems.
2. Provide care in the least restrictive setting necessary for safety and effectiveness.
3. Focus on promoting initial engagement and maintaining retention over time. This includes attention to appropriate housing and access to treatment, as addressed in Annotation I.

4. Consider multiple treatment contacts per week (including medication dispensing) for severely dependent patients in early recovery.
5. For DoD active duty, command or operational concerns may be taken into consideration.

Recommendations

6. Complement recovery support in the patient's community (e.g., Alcoholics Anonymous) and/or facilitate development of community support (Finney & Moos, 1998) (II-2, A)
7. Addressing identified concurrent problems improves outcomes (Kraft et al., 1997; McLellan et al., 1998; Avants et al., 1999) (I, A)
8. Individualize treatment in terms of intensity, setting, duration, and modality (Finney & Moos, 1998; IOM, 1990) (III, A)
9. Promote initial treatment engagement and retention (Crits-Cristoph & Siqueland, 1996; Finney & Moos, 1998; Gerstein & Harwood, 1990; Onken et al., 1997) (II-2, A)

I. Ensure Appropriate Housing And Access To Treatment

Objective

Facilitate access to treatment and promote a supportive recovery environment.

Annotation

The term "housing" is used generically as the residence of a patient while receiving treatment. It can involve the same setting within which treatment takes place or it can refer to a variety of living situations with varying degrees of supervision that are separate from the location of treatment services. Refer to Table 2 in Module R of the guideline for suggestions on housing options based on specific indications.

J. Negotiate Specific Rehabilitation Goals With The Patient

Objective

Specify the planned treatment regimen and promote patient adherence.

Annotation

0. Negotiate treatment goals that specifically identify and address relapse risks.
1. Review with the patient results of previous efforts at self-change and formal treatment experience, including reasons for treatment dropout.
2. Use empathic and non-judgmental (versus confrontational) therapist style.

Recommendations

3. Negotiate specific rehabilitation goals with the patient (Heinssen et al., 1995; Miller, 1995; Miller & Rollnick, 1991; Sanchez-Craig & Lei, 1986; Sobell et al., 1992; Stark, 1992) (II-1, A)
4. Review previous treatment and efforts at self-change with patient (Stark, 1992) (III, B)
5. Use empathic and non-judgmental (versus confrontational) therapist style (Hser, 1995; Miller et al., 1993; Najavits & Weiss, 1994) (I, A)

K. Initiate Addiction-Focused Psychosocial Therapy

Objective

Initiate addiction-focused psychosocial treatment that will help the patient establish early remission and prevent relapse to substance use.

Annotation

0. Indicate to the patient and significant others that treatment is more effective than no treatment.
1. Respect patient preference for the initial psychosocial intervention approach, since no single intervention has emerged as the treatment of choice.
2. Consider addiction-focused psychosocial interventions with the most consistent empirical support, several of which have been developed into published treatment manuals:
    - Behavioral marital therapy
    - Cognitive-behavioral coping skills training
    - Community reinforcement and other contingency-based approaches
    - Individual and group drug counseling
    - Motivational enhancement
    - Twelve-Step facilitation training
3. Emphasize that the most consistent predictor of successful outcome is retention in formal treatment or community support.
4. Promote active involvement in Twelve-Step programs (e.g., Alcoholics Anonymous and Narcotics Anonymous) that have been helpful to many and are widely available.
5. Use effective strategies for referral to mutual help programs in the community, addressing patient preferences and prior experiences.
    - Ask whether the patient has ever attended a self-help meeting.
    - Explore the patient's attitude and concerns about attending meetings.
    - Discuss the possible benefits.
    - Describe the range of meetings that are available.
    - Refer the patient to a specific meeting, at a specific time, date, and location.
    - Follow-up regarding meeting attendance and experience.

Recommendations

6. Indicate to the patient that treatment is effective (Gerstein & Harwood, 1990; IOM, 1990) (I, A)

7. Respect patient preference for the initial psychosocial intervention approach (Carroll & Schottenfeld, 1997; Crits-Cristoph & Siqueland, 1996; Finney & Moos, 1998) (I, A)
8. Consider behavioral marital therapy. (Stanton & Shadish, 1997; O'Farrell, 1993) (I, A)
9. Consider cognitive-behavioral coping skills training (Beck et al., 1993; Carroll, 1998; Kadden et al., 1992; Monti et al., 1989) (I, A)
10. Consider community reinforcement and other contingency-based approaches (Budney & Higgins, 1998; Meyers & Smith, 1995; Silverman et al., 1996) (I, A)
11. Consider individual and group drug counseling. (Mercer & Woody, 1999) (I, A)
12. Consider motivational enhancement. (Miller et al., 1992) (I, A)
13. Consider Twelve-Step facilitation training (Nowinski et al., 1992; Ouimette et al., 1997; Tonigan et al., 1996) (I, A)
14. Emphasize retention in formal treatment or community support (Finney & Moos, 1998; Simpson, 1997) (I, A)
15. Promote active involvement in Twelve-Step programs. (Humphreys, 1999) (II-2, A)

L. Initiate/Continue Treatment Of Coexisting Problems (e.g., Medical, Psychiatric, Family, Vocational, And/Or Legal) And Other Compulsive Behavior (e.g., Gambling Or Spending)

Objective

Provide comprehensive individualized treatment that will improve clinical outcome and functional status.

Annotation

0. Prioritize and address other coexisting biopsychosocial problems with services targeted to these areas, rather than increasing drug and alcohol counseling alone.
1. Treat concurrent psychiatric disorders consistent with VHA/DoD clinical practice guidelines (e.g., those for treating patients with Major Depressive Disorder or Psychoses) including concurrent pharmacotherapy.
2. Provide multiple services in the most accessible setting to promote engagement and coordination of care.
3. Monitor and address deferred problems and emerging needs through ongoing treatment plan updates.
4. Coordinate care with other providers.

Recommendations

5. Treat concurrent psychiatric disorders, including concurrent pharmacotherapy. (Mason et al., 1996; Nunes et al., 1995; Nunes et al., 1998; USDHHS, 1994) (I, A)
6. Target specific services to address other coexisting biopsychosocial problems. (McLellan et al., 1993, 1994, 1998) (I, A)

M. Is Patient Nicotine Dependent?

Objective

Identify patients with nicotine dependence for which cessation treatment may be effective.

Annotation

0. Nearly all daily nicotine users are nicotine dependent (See Module A, Annotation E, for the DSM-IV dependence criteria [305.1]).
1. Offer and recommend smoking cessation treatment to every patient who is dependent on nicotine. Use the VHA/DoD Clinical Practice Guideline To Promote Tobacco Use Cessation in the Primary Care Setting.
2. Identification and treatment of co-morbid nicotine dependence may improve recovery rates of other substance abuse orders.

N. Is Addiction-Focused Pharmacotherapy Indicated?

Objective

Consider appropriateness of addiction-focused pharmacotherapy for all patients.

Annotation

0. Consider addiction-focused pharmacotherapy for opioid dependence and/or alcohol dependence as part of a comprehensive treatment plan including addiction-focused psychosocial treatment and pharmacotherapy for co-existing psychiatric conditions.
1. Evaluate indications for pharmacotherapy in all patients with opioid and alcohol dependence. (See Tables 3 and 4 of Module R in the original guideline document for information on indications for use of naltrexone, disulfiram, and opioid agonists.)

Please refer to Module P: Addiction-Focused Pharmacotherapy of the original guideline document for, contraindications and regimen guidelines for naltrexone, disulfiram and opioid agonists.

O. Provide Periodic Reassessment Of Problems, Goals, And Response To Psychosocial Treatment And Pharmacotherapy

Objective

Periodically reassess response to treatment, change in treatment goals, or other indications for change in the treatment plan.

Annotation

0. Reassess and document clinical response throughout the course of treatment:
    - Daily in the acute inpatient setting, including reevaluation of the continued need for that level of care.

- At least weekly in the residential setting, including reevaluation of the continued need for that level of care.
- In the outpatient setting: within the first 10-14 days for a new episode of care; after the first 90 days of continuing care; and at least annually for long-term care

1. For patients receiving pharmacotherapy with disulfiram or naltrexone, transaminase levels should be reassessed monthly for the first 3 months and then every 3 months thereafter (see Module P, Annotation J in the original guideline document).
2. Modify treatment plans individually based on changes in a patient's clinical and psychosocial condition rather than imposing uniform treatment plans
3. Indications to change treatment intensity or provide adjunctive treatments may include:
    - Relapse based on self-report or urine toxicology
    - Increased risk of relapse (e.g., craving or personal loss)
    - Emergence or exacerbation of comorbid medical and psychiatric conditions
    - Suboptimal response to medication
    - Emergence of medication side effects
4. Discuss relapse as a signal to reevaluate the treatment plan rather than evidence that the patient cannot succeed or was not sufficiently motivated.
5. Target services to identified problems (e.g., psychiatric, medical, family/social, legal, vocational, and housing) that increase the risk of relapse, rather than increasing drug and alcohol counseling alone.
6. Consider care management for patients with persistently sub-optimal response, rather than routinely intensifying rehabilitation or discharging (See Module C: Care Management).
7. Consider reduced treatment intensity or discontinuing some treatment components based on:
    - Full, sustained remission
    - Greater involvement in community support
    - Improvements in other associated problem areas
8. Coordinate follow-up with the patient's primary medical or behavioral health provider during transitions to less intensive levels of care in order to reinforce progress and improve monitoring of relapse risks.

Recommendations

9. Modify treatment plans based on changes in a patient's clinical and psychosocial condition (ASAM, 1996) (III, A)
10. Discuss relapse as a signal to reevaluate the treatment plan (Miller & Rollnick, 1991; Marlatt & Gordon, 1985) (II, A)
11. Target services to identified problems that increase the risk of relapse (McLellan et al., 1997) (I, A)

P. Create Recovery Plan

Objective

Maximize the patient's chances for achieving his/her rehabilitation goals by summarizing, simplifying, and solidifying key recovery ingredients.

Annotation

Summarize on paper "the basic things I need to do to meet my rehabilitation goals", including the following:

0. Information on treatment appointments and mutual help meetings to attend
1. Recognizing relapse warning signs and triggers and appropriate coping responses
2. Maintaining contact with recovery support network

As part of discharge instructions, provide this to the patient to facilitate compliance with aftercare plans.

Q. Are There Indications To Continue Treatment In Specialty Care?

Objective

Optimize the duration of formal addiction-focused treatment consistent with the establishment of recovery support in the patient's community.

Annotation

0. Use the patient's progress in attaining recovery goals to guide treatment continuation, rather than uniform treatment plans.
1. Uniform length or intensity of care.
2. Consider patient report of craving and other subjective indications of relapse risk.
3. Emphasize the increased risk of relapse in early recovery and the importance of follow-up, until the patient establishes full-sustained remission (i.e., no dependence criteria met for 12 months).

R. Discontinue Treatment In Specialty Care; Arrange For Transition To Primary Care

Objective

Provide appropriate continuity of care to follow up with primary medical or behavioral health care provider.

Annotation

Discuss the impact of changes in substance use on other medical and psychiatric conditions and identify relapse risks for future monitoring. Arrange for continued monitoring of substance use and co-morbid conditions either in addiction specialty care or by the patient's primary medical or behavioral health care provider.

0. Schedule primary care follow-up within 90 days to reinforce recovery progress during the post-discharge period of highest risk for relapse.

1. Encourage patients to re-contact addiction-focused treatment providers for additional help as needed in preventing or promptly interrupting relapse.
2. For DoD active duty patients, addiction-focused treatment follow-up may be mandated for a period of 6-12 months from the time of initial referral (this may be referred to as "aftercare" in the DoD community).

S. Follow-up In Primary Care

Objective

Assure continuity of care with primary provider and promote abstinence or reduced use.

Annotation

Communicate the follow-up plan to the primary provider, including:

0. Monitor signs of use and ask the patient about specific quantity and frequency of use.
1. Monitor other biological indicators that may improve with abstinence (e.g., transaminase levels or hypertension).
2. Assess adherence to recovery plan.
3. Coordinate continued addiction-focused pharmacotherapy, if indicated.
4. Provide motivational support.
5. Discuss other areas of concern in the patient's life that may be prognostic indicators.
6. Encourage abstinence or reduced use that is consistent with patient's motivation and agreement.

Module S: Stabilization

A. Substance-Using Patient Who May Require Physiological Stabilization

This module addresses the management of patients who are physiologically dependent on alcohol or other sedative-hypnotics or opioids and at risk of withdrawal symptoms, or for whom the provider is uncertain about the level of withdrawal risk and seeks further evaluation.

B. Obtain History, Physical Examination, Mental Status Examination (MSE), Medication Including Over-The Counter (OTC), And Lab Tests As Indicated

Note: An assessment may already have been obtained as part of the patient's initial assessment.

Objective

Obtain clinical background information on the patient.

Annotation

1. Interview the patient and other collateral informants, where appropriate, about medical history and use of prescription and non-prescription medications before initiating extensive diagnostic testing.
2. Note any history of recent head trauma.
3. Order laboratory tests selectively, aiming to detect potential medical causes for the presenting symptoms, where indicated by:
    - Specific symptoms found on the medical review of systems
    - Evidence of unusual symptom profiles
    - History of atypical illness course
4. Screen for cognitive status, particularly in the elderly patient.
    - Consider a standardized instrument, such as Folstein's Mini-Mental State Examination (MMSE) using age and education-adjusted cut-off scores.
    - Consider using a standardized procedure, such as the Neurobehavioral Cognitive Status Exam, if the mental status screening is positive.

C. Is The Patient Medically Or Psychiatrically Unstable?

Objective

Identify the patient who needs to be stabilized before continuing in the algorithm.

Annotation

Patients with problems that require emergency care or urgent action should not be further managed in this algorithm. Emergency or urgent actions include unstable medical problems (e.g., acute trauma, myocardial infarction, and stroke) or unstable psychiatric problems (e.g., delirium and imminent risk of harm to self and/or others).

Refer to Module A: Assessment and Management in Primary Care of this summary and the original guideline document for methods of identifying patients with delirium, those who are at risk of harm to self or others, those who have serious psychiatric instability, or those with serious psychiatric instability.

Recommendations

1. Assess imminent risk for suicide (USPSTF, 1996) (II-2, A)
2. Note increased risk for violence (Hasting & Hamberger, 1997; Thienhaus & Piasecki, 1998) (III, A)
3. Offer counseling to patients at risk (Hirschfield & Russell, 1997; USPSTF, 1996) (III, A)
4. Arrange emergency treatment or possible hospitalization (APA, 1993; CSAT, 1995; USDHHS, 1993, 1995; USPSTF, 1996; VA Task Force) (III, A)

D. Provide Appropriate Care To Stabilize Or Consult
For DoD Active Duty: Keep Commanding Officer Informed

Objective

Provide services to stabilize the patient's condition.

Annotation

1. Implement suicide or high-risk protocols, as needed.
2. Review local policies and procedures with regard to threats to self or others. These policies reflect local and state laws and the opinion of the VA District Council and the DoD. Primary care, mental health, and administrative staff must be familiar with these policies and procedures.
3. For DoD active duty: follow service-specific mandates, as mental health/emergency referral is likely mandated.

E. Assess Level Of Intoxication And/Or Physiological Dependence

Objective

Obtain the necessary data to guide the patient's detoxification process.

Annotation

Indications for stabilization include intoxication or risk of withdrawal:

1. Intoxication:
    - The most common signs and symptoms involve disturbances of perception, wakefulness, attention, thinking, judgment, psychomotor behavior, and interpersonal behavior.
    - Patients should be medically observed at least until the blood alcohol level (BAL) is decreasing and clinical presentation is improving.
    - Highly tolerant individuals may not show signs of intoxication. For example, patients may appear "sober" even at blood alcohol levels well above the legal limit (e.g., 80 or 100 mg percent).
2. Consider withdrawal risk from each substance for patients using multiple substances.

Signs and Symptoms of Intoxication

<u>Alcohol and Sedative-Hypnotics</u>

- Slurred speech
- Incoordination
- Unsteady gait
- Nystagmus
- Impairment in attention or memory
- Stupor or coma

<u>Cocaine or Amphetamine</u>

- Tachycardia or bradycardia
- Pupillary dilation

- Elevated or lowered blood pressure
- Perspiration or chills
- Nausea or vomiting
- Psychomotor agitation or retardation
- Muscular weakness, respiratory depression, or chest pain
- Confusion, seizures, dyskinesias, dystonias, or coma

Opiate

- Pupillary constriction (or dilation due to anoxia from overdose)
- Drowsiness or coma
- Slurred speech
- Impairment in attention or memory
- Shallow and slow respiration or apnea

Note: Acute opiate intoxication can present as a medical emergency with unconsciousness, apnea, and pinpoint pupils.

Symptoms of withdrawal from sedative-hypnotics or alcohol

22. Signs and symptoms of withdrawal from sedative-hypnotics or alcohol include two or more of the following, developing within several hours to a few days after cessation or reduction in heavy and prolonged use:
    - Autonomic hyperactivity (e.g., diaphoresis, tachycardia, and elevated blood pressure)
    - Increased hand tremor
    - Insomnia
    - Nausea and vomiting
    - Transient visual, tactile, or auditory hallucinations or illusions
    - Delirium tremens (DTs)
    - Psychomotor agitation
    - Anxiety
    - Irritability
    - Grand mal seizures
23. The potential for a withdrawal syndrome can be gauged only imprecisely by asking the patient the pattern, type, and quantity of recent and past substance use.
24. Consider standardized measures to assess the severity of withdrawal symptoms. The Clinical Institute Withdrawal Assessment for Alcohol-Revised (CIWA-Ar) has good reliability and validity for assessing severity of withdrawal symptoms from alcohol (see Appendix A-1 of the original guideline document).
25. CIWA-Ar has 10 provider ratings. Interpret total scores as follows:
    - Minimal or absent withdrawal: $\leq$9
    - Mild to moderate withdrawal: 10-19
    - Severe withdrawal: $\geq$20

Symptoms of opioid withdrawal

26. The opioid withdrawal syndrome can be protracted with intense symptoms, though the syndrome itself poses virtually no risk of mortality. However, there is significant mortality risk from overdose

for those who relapse following unsuccessful detoxification attempts, as a result of loss of opioid tolerance.

27. Signs and symptoms of opioid withdrawal include any or all of the following, which may develop at a time appropriate for the ingested opioid (e.g., within 6-12 hours after the last dose of a short acting opioid, such as heroin, or 36-48 hours after the last dose of a long acting opioid, such as methadone):
    - Craving for opioids
    - Restlessness or irritability
    - Nausea or abdominal cramps
    - Increased sensitivity to pain
    - Muscle aches
    - Dysphoric mood
    - Insomnia or anxiety
    - Pupillary dilation
    - Sweating
    - Piloerection (i.e., gooseflesh)
    - Tachycardia
    - Vomiting or diarrhea
    - Increased blood pressure
    - Yawning
    - Lacrimation

Physiological dependence

28. Determine the presence of tolerance or withdrawal, as documented in DSM-IV diagnostic criteria.
29. Tolerance is identified by either of the following:
    - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - Markedly diminished effect with continued use of the same amount of the substance.
30. Withdrawal is identified by either of the following:
    - The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).
    - The same (or a closely-related) substance is taken to relieve or avoid withdrawal symptoms.
31. Evaluate patients using multiple substances (e.g., opioids and sedative-hypnotics) for risk of withdrawal from each substance.

Recommendations

Consider using standardized assessment of withdrawal symptoms (Sullivan et al., 1989; Gossop, 1990; Zilm & Sellers, 1978) (II-2, A)

F. Is There Clinical Justification For Prescribed Opioid Or Sedative-Hypnotic Use?

Objective

Clarify the underlying clinical condition being managed through opioid or sedative-hypnotic use.

Annotation

0. Distinguish patients with legitimate pain and/or anxiety disorders who develop physiological tolerance during long-term use of prescribed medications, from those with markers of "addict behavior" (e.g., seeking medications for other than pain, seeking prescriptions from multiple providers, increasing the dose without consultation, frequent "losses" of medications, intoxication, or buying medication on the street).
1. Evaluate opioid dependent patients for severe acute or chronic physical pain that may require appropriate short-acting opioid agonist medication, in addition to the medication needed to prevent opioid withdrawal symptoms (see also the American Society of Addiction Medicine policy statement).
2. Consider patients with a history of substance use disorders to be at elevated risk of receiving inadequate therapy for pain or anxiety.
3. Prescribe opioid analgesic medication (in cases of severe pain disorders) or sedative-hypnotic medication (in cases of severe anxiety or seizure disorders), when medically indicated, even if the patient has a history of substance abuse disorder and provided that the patient's medical condition is:
    - Diagnosed correctly, including physical examination, review of past records, and appropriate consultation
    - Acute enough to justify the use of opioid analgesics
    - Documented in the clinical record
4. Consult with an addiction specialist, if uncertain whether to prescribe an opioid analgesic or sedative-hypnotic medication to a substance dependent patient with a current or historical substance abuse disorder.

Recommendations

5. Distinguish opioid addiction from opioid dependence (Portenoy, 1994; American Geriatrics Society Panel, 1998) (III, A)
6. Consider patients with substance use disorders to be at elevated risk of receiving inadequate pain therapy (Portenoy et al., 1997; Savage, 1999) (III, B)

G. Adjust Medications As Necessary And Monitor Medical Condition

Objective

Assure appropriate symptom management and safety monitoring for medically indicated opioid or sedative-hypnotic prescription.

Annotation

0. Consider prescribing a higher medication dose for adequate symptom relief of physiologically tolerant, non-addicted patients.
1. Set reasonable behavioral and dosing limits and increase monitoring when pharmacologically treating pain or anxiety in patients with a history of substance dependence.

- Prescribe medication on a fixed schedule, rather than as needed (PRN).
- Use long-acting medication (such as sustained-release morphine or diazepam), rather than short acting medication (such as oxycodone/acetaminophen or alprazolam).
- Limit prescription medication to what is needed until the next appointment.
- Follow the patient weekly or biweekly, at least at the beginning of therapy.
- Write out the prescription as you would a check, to prevent alteration.

2. Consider using written contracts for patients receiving opioids or sedative-hypnotics long term, and monitor their conditions carefully, with relatively frequent visits, urine drug screens, and use of collateral informants.
3. Discontinue prescription (with detoxification, if necessary) and refer to a substance abuse disorder specialist, if abuse of opioid or sedative-hypnotic medications occurs.

Recommendations

4. Consider prescribing a higher opioid dose for adequate pain relief of physiologically tolerant, non-addicted patients (Portenoy, 1994; Portenoy et al., 1997) (III, B)
5. Set reasonable behavioral and dosing limits and increase monitoring when pharmacologically treating pain or anxiety in patients with substance dependence (Portenoy, 1994; Portenoy et al., 1997; Scimeca et al., 2000; Longo et al., 2000) (III, A)

H. Is The Patient Opioid Dependent, Appropriate For, And Willing To Engage In Opioid Agonist Therapy (OAT)?

Objective

Assure careful consideration of opioid agonist therapy as the first line treatment for opioid dependence.

For DoD active duty, opioid agonist generally not a treatment option.

Annotation

Opioid dependence is a cluster of cognitive, behavioral, and physiological symptoms characterized by repeated self-administration and usually results in opiate tolerance, withdrawal symptoms, and compulsive drug taking, despite negative consequences. While new Federal regulatory language uses the term "opiate addiction", the diagnostic term "opioid dependence" will be used here for consistency with the rest of the guideline. Dependence may occur with or without the physiological symptoms of tolerance and withdrawal. Opioid agonist therapy for opioid dependence consists of administering an opioid agonist medication, such as methadone or levo-alpha-acetylmethadol (LAAM), in combination with a comprehensive range of medical, counseling, and rehabilitative services. By administering an opioid to prevent withdrawal, reduce craving, and reduce the effects of illicit opioids, the opioid dependent

patient is able to focus more readily on recovery activities. When compared to detoxification attempts, Opioid agonist therapy is more successful in achieving the long-term goal of reducing opioid use and associated negative medical, legal, and social consequences.

Provide access to opioid agonist therapy for all opioid dependent patients, under appropriate medical supervision and with concurrent addiction-focused psychosocial treatment (See Module R: Assessment and Management in Specialty Care).

0. Consider methadone maintenance for its documented efficacy in reducing illicit opioid use, HIV risk behavior, and drug-related criminal behavior.
1. Consider levo-alpha-acetylmethadol (LAAM), a long-acting, synthetic mu-agonist, a safe and effective alternative to methadone maintenance.
2. Consider the acceptability and feasibility of regular clinic attendance. Under U.S. Federal regulations of opioid agonist therapy programs, for the first 90 days of treatment the patient should attend clinic at least six days per week for methadone or three times per week for levo-alpha-acetylmethadol.
3. See below for indications, contraindications, side effects, and drug interactions of methadone and levo-alpha-acetylmethadol.

Agonist Therapy for Opioid Dependence

Indications

- Opioid dependence $\geq$ 1 year
- Two or more unsuccessful opioid detoxification episodes within a 12 month period
- Relapse to opioid dependence within 2 years from opioid agonist therapy discharge

Contraindications

- Allergy to agent
- Concurrent enrollment in another opioid agonist therapy
- Significant liver failure
- Use of opioid antagonists (e.g., naloxone, nalmefene, or naltrexone)

Side Effects

- Common: constipation
- Less common: sexual dysfunction

Drug Interactions

- Drugs that reduce serum methadone level: phenytoin, carbamazapine, rifampin, barbiturate sedative-hypnotics, some anti-virals, ascorbic acid, and chronic ethanol use

- Drugs that increase serum methadone level: cimetidine, ketoconazole, fluconazole, amitriptyline, diazepam, and fluvoxamine maleate

Recommendations

15. Consider opioid agonist therapy the first line treatment for opioid dependence (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998; Sees et al., 2000) (I, A)
16. Methadone maintenance, at adequate doses, is efficacious in reducing opioid use (Strain et al., 1993a, 1993b; Marsch, 1998; Johnson, 2000) (I, A)
17. Levo-alpha-acetylmethadol (LAAM) maintenance, at adequate doses, is an effective alternative to methadone maintenance (Eissenberg et al., 1997; Glanz et al., 1997) (I, A)

I. Initiate Opioid Agonist Therapy (OAT)

Objective

Provide appropriate dosing and relapse monitoring to promote effective outcomes.

Annotation

Methadone

For newly-admitted patients, the initial dose of methadone should not exceed 30 mg, and the total dose for the first day should not exceed 40 mg, without provider documentation that 40 mg did not suppress opiate withdrawal symptoms.

Under usual practices, a stable target dose is greater than 60 mg/day and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Effective May 2001, U.S. Federal regulations no longer required the opioid agonist therapy program physician to justify in the patient record doses >100 mg/day.

Levo-alpha-acetylmethadol (LAAM)

For newly admitted patients, the initial 48-hour dose of levo-alpha-acetylmethadol should not exceed 40 mg. After dose induction, a stable target dose is usually at least 50/50/70 mg administered on Monday/Wednesday/Friday and most patients will require considerably higher doses in order to achieve a pharmacological blockade of reinforcing effects of exogenously administered opioids. Friday doses are increased 40% to compensate for the 72-hour inter-dose interval. For patients on established doses of methadone, the relative potency of 48-hour levo-alpha-acetylmethadol doses is 1.2-1.3 times the daily methadone dose.

Opioid Agonist Therapy

Providers should adjust opioid agonist doses to maintain a therapeutic range between signs/symptoms of overmedication (e.g., somnolence, miosis, itching, hypotension, and flushing) and opioid withdrawal (e.g., drug craving, anxiety, dysphoria, and irritability).

Deliver opioid agonist therapy in the context of a complete treatment program that includes counseling or psychotherapy (See Module R: Assessment and Management in Specialty Care).

- Methadone, combined with weekly counseling for at least four weeks after admission, followed by at least monthly counseling, has been shown to be more effective than methadone alone.
- Availability of more frequent counseling is associated with less illicit drug use.
- No specific form of psychosocial intervention has consistently been shown to be more or less efficacious.
- Programs with high-quality social services show better treatment retention.
- Programs must provide adequate urine toxicology for drugs of abuse, including a minimum of eight random tests per year per patient.

Recommendations

5. Methadone target dose is typically >60 mg/day (Strain et al., 1999; Preston et al., 2000) (I, A)
6. Methadone, combined with regular counseling, is more effective than methadone alone (McLellan et al., 1993) (I, A)
7. Frequent counseling is associated with less illicit drug use (Magura et al., 1999) (II-2, A)
8. High-quality social services show better treatment retention (Condelli, 1993) (I, A)
9. Levo-alpha-acetylmethadol (LAAM) target dose is typically at least 50/50/70 mg on Monday/Wednesday/Friday (Jones et al., 1998; Eissenberg et al., 1997) (I, A)

J. Is Detoxification Indicated?

Objective

Identify patients who need detoxification from alcohol, sedative-hypnotics, or opioids.

Annotation

Detoxification is an essential initial gateway in preparing many patients for additional treatment. Pharmacological detoxification is warranted only for alcohol, sedative-hypnotics, and opioids. For nicotine dependence, refer to the VHA/DoD Clinical Practice Guideline Tobacco Use Cessation in the Primary Care Setting . Other drugs of abuse do not require pharmacological management for withdrawal.

Indications for detoxification from alcohol or sedative-hypnotics

0. Medical monitoring of detoxification should be provided for dependence on central nervous system (CNS) depressants, due to the potential severity of untreated withdrawal in severely dependent persons.
1. Mild withdrawal symptoms that are not accompanied by complicating comorbidities may not require pharmacological management and may respond sufficiently to generalized support, reassurance, and frequent monitoring.
2. Detoxification from sedative-hypnotics is indicated when there is physical dependence in the absence of clinical indications for ongoing treatment (e.g., anxiety or panic disorder) or when accompanied by "addict behavior" (e.g., prescriptions from multiple providers, patient escalating doses without provider consultation, or buying medications on the street).

Indications for opioid detoxification

3. It is difficult to identify opioid addicted patients with good prognosis for successful opioid detoxification; however, the following are relative indications:
    - Briefer and less severe addiction history that does not meet regulatory criteria for opioid agonist treatment (see Annotation H)
    - Active commitment to an abstinence-oriented recovery program (e.g., monitored naltrexone, mutual help program involvement, and therapeutic community participation)
4. Detoxification is contraindicated for individuals with two or more unsuccessful detoxification episodes within a 12-month period. Such patients must be assessed by an opioid treatment program physician for alternatives to detoxification.

Recommendations

5. Mild withdrawal symptoms that are not accompanied by complicating comorbidities may respond sufficiently to generalized support, reassurance, and frequent monitoring (APA, 1995) (II-2, D)

K. Assess For Appropriate Level Of Professional Monitoring For Detoxification
Address Psychosocial Barriers to Treatment Engagement

Objective

Ensure safety during detoxification in the least restrictive environment and promote long-term successful recovery.

Annotation

Determine appropriate level of care, based on:

0. Severity of current and past withdrawal symptoms (e.g., use of Clinical Institute Withdrawal Assessment for Alcohol - Revised [CIWA-Ar] for

alcohol or the Short Opiate Withdrawal Scale (SOWS) or Clinical Institute Narcotics Assessment (CINA) for opioids).

1. Severity of comorbid conditions.
2. Patient's treatment acceptance and potential to complete detoxification.
3. Recovery environment and other American Society of Addiction Medicine (ASAM) criteria (see Web site: http://www.asam.org).

Recommendations

4. Determine appropriate level of care (ASAM, 1996) (III, A)
5. Use standardized assessment of withdrawal symptoms (Sullivan et al., 1989; Gossop, 1990; Zilm & Sellers, 1978) (II, A)

L. Does Patient Require Inpatient Detoxification?

Objective

Identify the appropriate setting for safe and effective withdrawal management.

Annotation

0. Ambulatory detoxification has the potential advantages of:
    - Facilitating continuity of care in the outpatient setting
    - Reducing disruption to the patient's life
    - Lowering costs in the outpatient setting
1. While no definitive standard exists for setting up an ambulatory detoxification protocol, there should be systematic assessment and consistent monitoring.
2. Inpatient detoxification allows closer monitoring of withdrawal symptoms and higher likelihood of completing the detoxification protocol.
    - There are fewer logistic medical and legal concerns (e.g., arranging for patient transportation, driving during the course of detoxification, and the ability to give informed consent).
    - While patients are more likely to complete the inpatient detoxification protocol, long-term outcomes do not indicate a difference between inpatient and outpatient detoxification programs.
3. Consider the following indications for inpatient detoxification:
    - Current symptoms of moderate to severe alcohol withdrawal (e.g., Clinical Institute Withdrawal Assessment for Alcohol - Revised [CIWA-Ar] score $\geq$ 10)
    - History of delirium tremens (DTs) or withdrawal seizures
    - Inability to tolerate oral medication
    - Imminent risk of harm to self or others
    - Recurrent unsuccessful attempts at ambulatory detoxification
    - Reasonable likelihood that the patient will not complete ambulatory detoxification (e.g., due to homelessness)
    - Active psychosis or severe cognitive impairment
4. Because medical complications and withdrawal severity are often the reasons for an inpatient detoxification admission, inpatient programs

should provide adequate, on-site medical staffing in order to ensure patient safety during detoxification.

Recommendations

Indications for inpatient detoxification (ASAM, 1996) (III, A)

M. Admit To Inpatient Detoxification
Initiate Ambulatory Detoxification

Objective

Provide a safe withdrawal from alcohol or sedative-hypnotics and prepare the patient for ongoing addiction treatment.

Annotation

Alcohol detoxification

Facilities should develop local alcohol detoxification pathways, taking into consideration the following principles:

0. Use either of the following two acceptable pharmacotherapy strategies for managing alcohol withdrawal symptoms:
    - Symptom-triggered therapy, where patients are given medication only when signs or symptoms of withdrawal appear (e.g., PRN dosing).
    - A predetermined fixed medication dose, with gradual tapering over several days.
1. Consider standardized assessments, such as the Clinical Institute Withdrawal Assessment for Alcohol - Revised [CIWA-Ar] scale for alcohol withdrawal, to guide dosing decisions (e.g., if and when to dose).
2. Consider the following empirically validated procedures for ambulatory alcohol detoxification monitoring as safe and effective alternatives to inpatient approaches:
    - Medical or nursing staff should assess the patient in person, either daily or every other day (patient contact may be made by telephone on other days), to include:
        - Patient report of any alcohol use the previous day
        - Reported medication intake compared to the medication dispensed the previous day
        - Tremor, restlessness, and previous night's sleep
        - Skin (e.g., color and turgor)
    - Urine toxicology or a breathalyzer test of blood alcohol concentration (BAC) should be completed.
    - The patient should be medically cleared before initiating or continuing outpatient detoxification, if the daily screening is positive for any one of the following:
        - Blood sugar $\geq$400 or positive anion gap

- History of recent hematemesis or other gastrointestinal (GI) bleeding disorder
- Bilirubin ≥3.0
- Creatinine ≥2.0
- Systolic blood pressure ≥180 or diastolic blood pressure ≥110
- Unstable angina
- Temperature ≥101 degrees
- Blood alcohol concentration (BAC) ≥0.08 on two outpatient visits

3. For the treatment of alcohol withdrawal, use benzodiazepines over non-benzodiazepine sedative-hypnotics because of documented efficacy, decreased abuse potential, and a greater margin of safety. Benzodiazepines are the drug of choice because they reduce withdrawal severity, incidence of delirium, and seizures. All benzodiazepines appear to be effective.
4. For geriatric patients, start with lower doses of benzodiazepines than for younger adults.
5. For managing alcohol withdrawal, carbamazepine can be used as an effective alternative to benzodiazepines.
6. Other agents, such as beta-blockers, dilantin, and clonidine, are generally not considered as appropriate monotherapy for alcohol withdrawal, but may be considered in conjunction with benzodiazepines in certain patients.
7. During and after detoxification, emphasis should be placed on engagement in ongoing addiction treatment.

Sedative-hypnotics detoxification (e.g., benzodiazepines)

There are three general treatment strategies for patients withdrawing from other sedative-hypnotic medications at doses above the therapeutic range, for a month or more:

8. Substitute phenobarbital for the addicting agent and taper gradually.
    - The average daily sedative-hypnotic dose is converted to a phenobarbital equivalent and divided into 3 doses per day for 2 days. Detailed information on phenobarbital equivalencies for sedative hypnotics can be found in Goodman and Gilman's The Pharmacological Basis of Therapeutics-Ninth Edition (1996).
    - Phenobarbital dose should be reduced by 30 mg per day, beginning on day 3.
9. For patients on a shorter acting benzodiazepine, substitute a longer acting benzodiazepine (e.g., chlordiazepoxide) and taper 10% per day, over 1 to 2 weeks.
10. Gradually decrease the dosage of the long-acting substance the patient is currently taking.

Opioid detoxification

11. Focus treatment of opioid withdrawal on facilitating entrance into comprehensive long-term treatment, as well as alleviating acute symptoms.

12. The preferred method of opioid detoxification remains short-term substitution therapy with methadone:
    - Use initial doses sufficient to suppress signs and symptoms of withdrawal, usually 30-40 mg/day.
    - Set the length of the taper period based on the treatment setting and goal of the detoxification. Dose decreases of more than 5 mg/day are generally poorly tolerated.
13. Detoxification can usually be accomplished in 4-7 days in an inpatient setting, to quickly achieve opioid abstinence prior to treatment in a drug-free setting.
14. Longer taper periods should be used in the outpatient setting to minimize patient discomfort and maximize chances of success.
15. A period of 21 days is generally sufficient for short-term outpatient detoxification in the most stable and motivated individual. However, many patients presenting for treatment have very chaotic lives and should receive opioid agonist for a period of extended stabilization, before they can realistically hope to maintain a drug-free lifestyle. Frequently, long-term detoxification occurs in the setting of an opioid agonist therapy program. Longer-term detoxification protocols frequently allow for a 21-day or 180-day detoxification.
16. The 180-day stabilization/detoxification regimen, done within an opioid agonist therapy program, should be considered to work on patients' early recovery problems, while stabilized on a relatively low dose (50-60 mg/day) of methadone. Stabilization is followed by short-term detoxification from methadone and transition to a drug-free rehabilitation program (for details refer to Table 3, Module S, in the original guideline document).
17. Clonidine, an alpha-adrenergic agonist, can be considered as an effective alternative for inpatient opioid detoxification; however, outpatient success is much lower.

Recommendations

18. Use symptom-triggered therapy or gradual dose tapering over several days for alcohol withdrawal management (Hayashida et al., 1989; Mayo-Smith, 1997; Saitz et al., 1994; APA, 1995; CSAT, 1995) (I, A)
19. Consider ambulatory alcohol detoxification, when indicated (Hayashida et al., 1989) (I, B)
20. Use benzodiazepines over non-benzodiazepine sedative-hypnotics for alcohol withdrawal management (Mayo-Smith, 1997) (I, A)
21. For managing alcohol withdrawal, carbamazepine can be used as an effective alternative to benzodiazepines (Malcolm et al., 1989) (II, B)
22. Gradually decrease the dosage of the sedative-hypnotic or substitute phenobarbital for the addicting agent and taper gradually (CSAT, 1995; Smith & Wesson, 1994) (III, A)
23. During opioid detoxification, facilitate engagement in comprehensive long-term treatment (Simpson & Sells, 1990; Magura & Rosenblum, in press) (II-2, A)
24. Use short-term agonist substitution therapy for opioid detoxification (Strain & Stitzer, 1999) (III, A)

N. Was Detoxification Successful?

Objective

Identify patients in need of additional detoxification or stabilization before proceeding with further evaluation or treatment.

Annotation

According to Mattick & Hall (1996), detoxification is successful to the degree the patient:

- Is physiologically stable
- Avoids hazardous medical consequences of withdrawal
- Experiences minimal discomfort
- Reports being treated with respect for his or her dignity
- Completes the detoxification protocol (e.g., no longer requires medication for withdrawal symptom management)
- Engages in continuing care for substance abuse disorder

O. Is Care Management Indicated?

Objective

Identify patients with substance use disorders who can benefit from implementation of a care management plan.

Annotation

If detoxification is unsuccessful, consider one of the following:

0. A more intensive level of care for detoxification (e.g., inpatient) [Return to Box 11].
1. Care Management, if detoxification is not indicated or acceptable to the patient [see Module C].

For some patients, repeated detoxification episodes may have a cumulative motivating effect in preparation for ongoing treatment.

Quality of Evidence Grading

I. Evidence is obtained from at least one properly randomized clinical trial (RCT).

II-1. Evidence is obtained from well-designed controlled trials without randomization.

II-2. Evidence is obtained from well-designed cohort or case-control analytical studies, preferably from more than one center or research group.

II-3. Evidence is obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of the introduction of penicillin treatment in the 1940's) could also be regarded as this type of evidence.

III. Opinions of respected authorities are based on clinical experience, descriptive studies and case reports, or reports of expert committees.

Strength of Recommendation Grading

A. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is useful/effective, always acceptable, and usually indicated.
B. A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered useful/effective.
C. A recommendation that is not well established, or for which there is conflicting evidence regarding usefulness or efficacy, but which may be made on other grounds.
D. A recommendation, based on evidence or general agreement, that a given procedure or treatment be considered not useful/effective.
E. A strong recommendation, based on evidence or general agreement, that a given procedure or treatment is not useful/effective, or in some cases may be harmful, and should be excluded from consideration.

CLINICAL ALGORITHM(S)

Algorithms are provided for the management of substance use disorders, including:

- Module A: Assessment and Management in Primary Care
- Module C: Care Management
- Module P: Addiction-Focused Pharmacotherapy
- Module R: Assessment and Management in Specialty Care
- Module S: Stabilization

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The development process for the guideline was evidence-based whenever possible. Evidence-based practice integrates clinical expertise with the best available clinical evidence derived from systematic research. Where evidence was ambiguous or conflicting, or scientific data were lacking, the clinical experience within the multidisciplinary group guided the development of consensus-based recommendations.

The quality of the evidence is specifically stated for each recommendation (see "Major Recommendations" section).

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

General Potential Benefits

- Improved screening process
- Efficient and effective initial assessment process
- Establishment of initial intervention, including referral, for non-dependent users, matching treatment to patient needs, increased use of pharmacotherapy and psychotherapy and the monitoring of its affects on the patient, improvement in the continuity of care and determination of referral criteria
- Improved rates of remission of substance use disorders
- Improvement in coexisting biopsychosocial problems and health-related quality of life
- Reduction in need for high-intensity health care services
- Reduction in rate of relapse
- Maintenance of progress
- Reduction in the rate of illness progression
- Improved health outcomes

Specific potential benefits of treatment

- Brief intervention. Multiple randomized clinical trials have demonstrated the efficacy of brief interventions by physicians in primary care settings.
- Care management. The care management approach to alcohol use disorders has been shown to improve outcome in two randomized controlled trials
- Agonist therapy for opioid dependence. Evidence consistently shows that patients have better outcomes when maintained with an agonist than a placebo or than when provided long-term detoxification.
- Naltrexone. Studies show safety and efficacy for up to several years of treatment at standard doses.
- Addiction-focused psychosocial therapy. Available qualitative and quantitative reviews consistently conclude that psychosocial treatment is more effective than no treatment and where indicated, pharmacotherapy with psychosocial treatment is more effective than pharmacotherapy alone.

POTENTIAL HARMS

- Opioid Agonists (Methadone and levo-alpha-acetylmethadol [LAAM])

  Side effects: A common side effect is constipation. Less common side effects are sexual dysfunction and QT interval prolongation (LAAM).

- Naltrexone

  Side effects: A common side effect is nausea. Other side effects include headache, dizziness, nervousness, fatigue, insomnia, vomiting, anxiety, and somnolence

- Disulfiram

  Side effects: Common side effects (usually mild and self-limiting) including somnolence, metallic taste, and headache. Less common, but more serious side effects, include hepatotoxicity, peripheral neuropathy, psychosis, and delirium. The severity of disulfiram-ethanol interaction varies considerable among patients and is generally dose-related, causing vasodilatation, flushing, hypotension, nausea, vomiting, dizziness, tachycardia, cardiac arrhythmias, myocardial infarction/stroke in susceptible patients, and even death from cardiac complications in older patients.

  Drug-drug interactions may occur with all of the above medications. See Module P in the original guideline document for a tabulated list of such drugs.

CONTRAINDICATIONS

CONTRAINDICATIONS

- Opioid Agonists (Methadone and levo-alpha-acetylmethadol [LAAM])

  Contraindications: Contraindications include allergy to agent, concurrent enrollment in another opioid agonist therapy, significant liver failure, use of opioid antagonists (e.g., naloxone, nalmefene, or natltrexone), For LAAM, electrocardiogram with QT interval > .45 seconds

- Naltrexone

  Contraindications: Contraindications include pregnancy; opioid withdrawal; opioid dependence, with use within past week; medical condition requiring opioid medication; severe hepatic dysfunction (i.e., transaminase levels > 3 times normal, or liver failure); severe renal failure; allergy to naltrexone.

- Disulfiram

  Contraindications: Contraindications include pregnancy; severe cardiovascular, respiratory, or renal disease; severe hepatic dysfunction (i.e., transaminase levels >3 times upper limit of normal or in liver failure); severe psychiatric disorders, especially psychotic and cognitive disorders and suicidal ideation; poor impulse control; previous disulfiram-ethanol reaction; metronidazole or ketoconazole therapy, which already induce a similar reaction to alcohol; allergy to disulfiram.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change, as scientific knowledge and technology advances and patterns evolve. The ultimate

judgment regarding a particular clinical procedure or treatment course must be made by the individual clinician, in light of the clinical data presented by the patient, patient preferences, and the diagnostic and treatment options available.

- Treatment must always reflect the unique clinical issues in an individual patient-clinician situation. Due to the nature of the algorithmic format, the specific pharmacological and psychosocial treatments for patients with substance use disorders are included in separate boxes. It is recognized, however, that clinical practice often requires a nonlinear approach and concurrent processes that combine a number of different treatment modalities.
- In substance use disorders, dimensions such as social support networks and occupational investment—found to be important in highly effective programs—may not lend themselves to study through a randomized clinical trial. Therefore, the strength of evidence grade does not always reflect the importance of the recommendation to patient care. The specific language used to formulate each recommendation conveys panel opinion of both the clinical importance attributed to the topic and the strength of evidence available.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The U.S. Veterans Health Administration and the U.S. Department of Defense are developing indicators to measure the impact of this guideline on the quality of care.

Pocket guides for management of substance abuse disorder are also available for primary care and specialty care practitioners.

IMPLEMENTATION TOOLS

Clinical Algorithm
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

RELATED QUALITY TOOLS

- Management of Substance Use Disorders Algorithm: Module A -- Primary Care

- Management of Substance Use Disorders Algorithm: Module C -- Care Management

- Management of Substance Use Disorders Algorithm: Module R -- Rehabilitation - Specialty Care

- Management of Substance Use Disorders Algorithm: Module P -- Pharmacotherapy

- Management of Substance Use Disorders Algorithm: Module S -- Stabilization

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders Guideline Summary: Primary Care

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders Guideline Summary: Specialty Care Rehabilitation

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders: Primary Care Pocket Guide

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders: Specialty Care Pocket Guide

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders: Specialty Care Pharmacotherapy Pocket Guide

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders: Primary Care Key Points Card

- Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Substance Use Disorders: Specialty Care Key Points Card

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Management of Substance Use Disorders Working Group. VHA/DoD clinical practice guideline for the management of substance use disorders. Washington (DC): Veterans Health Administration, Department of Defense; 2001 Sep. Various p. [207 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

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GUIDELINE DEVELOPER(S)

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

Veterans Health Administration National Clinical Practice Guideline Council - Federal Government Agency [U.S.]

GUIDELINE STATUS

This is a current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Veterans Health Administration (VHA) Web site.

Print copies: Available from the Department of Veterans Affairs, Veterans Health Administration (VHA), Office of Quality and Performance (10Q), 810 Vermont Ave. NW, Washington, DC 20420.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- VHA/DoD clinical practice guideline for the management of substance use disorders – primary care key points. Washington (DC): Department of Veterans Affairs (U.S.); 2001 Aug. 2 p.
- VHA/DoD clinical practice guideline for the management of substance use disorders – specialty care key points. Washington (DC): Department of Veterans Affairs (U.S.); 2001 Aug. 2 p
- Guideline summary on primary care. Washington (DC): Department of Veterans Affairs (U.S.); 2001 Aug. 10 p.
- Guideline summary on specialty care. Washington (DC): Department of Veterans Affairs (U.S.); 2001 Aug. 26 p

These and other companion documents, such as "Pocket Cards", are available at the Veterans Health Administration (VHA) Web site.

In addition, the VHA Web site provides references to related guidelines, performance measures, and other resources.

Also available:

- Guideline for Guidelines. Draft. Washington (DC): Veterans Health Administration, Department of Veterans Affairs. Available at the Veterans Health Administration (VHA) Web site Vermont Ave. NW, Washington, DC 20420.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 9, 2002. The information was verified by the guideline developer on September 25, 2002.

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